NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Harvoni Tablet/Pellet Pack/Ledipasvir-Sofosbuvir – Continuation PA Request Form

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: 28
11. Length of Therapy (in days): ☐ 4 More Weeks ☐ 16 More Weeks

Clinical Information

1. Have HCV RNA labs been collected four (4) or more weeks after the initial prescription fill date? (Medical documentation with results are required)? ☐ **Yes** ☐ **No**
2. Do the results of the HCV RNA labs indicate a response to therapy (≥ 2 log reduction in HCV RNA or HCV RNA <25 IU/mL)? ☐ **Yes** ☐ **No**

At week 4 or later of the treatment cycle:
HCV RNA (IU/ml): _____
And/or log 10 value: _____

Before treatment documented on original Prior Authorization request:
HCV RNA (IU/ml): _____
And/or log 10 value: _____

3. Has the beneficiary exhibited **NO** signs of high risk behavior (i.e. recurring alcoholism, IV drug use, etc.)? ☐ **Yes** ☐ **No**
4. Has the beneficiary failed to complete HCV disease evaluation appointments and procedures (Should be evident in follow-up reviews)? ☐ **Yes** ☐ **No**
5. Is the beneficiary compliant to the regimen as verified by the prescriber and beneficiary's medication fill history (review Rx history and dispensing for compliance)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.